Section E
Medicare Part B medical insurance

Medicare Part B medical

Medicare Part B medical insurance covers:

- Physicians' services
- Outpatient hospital care
- Ambulance services
- Prosthetic devices
- Medical equipment
- Some preventive services

The Part B beneficiary costs include a monthly premium, an annual deductible, coinsurance and excess charges.

1. The monthly premium is $96.40 (2009).
    A. Medicare Part B is optional; however, a late enrollment penalty will apply in certain circumstances if you do not take the Part B option.
    B. The Part B premium is normally deducted from the Social Security check.
    C. For persons who are enrolled in Part B but do not receive a Social Security check, bills are issued for premiums every three months.
    D. American citizens and lawfully admitted aliens who are not covered by Social Security and are not eligible for premium-free Part A of Medicare, pay the same Part B premium if they choose to purchase Part B.

2. Part B benefit period/deductible
    A. The calendar year, Jan. 1–Dec. 31, is the Part B benefit period. A beneficiary is responsible for the first $135 (2009) of Part B approved charges in each calendar year.
    B. Payment for services not covered by Medicare and charges in excess of the Medicare approved charges do not apply to the deductible.

3. Part B coinsurance
    A. Medicare Part B pays 80 percent of the charges approved for coverage.
    B. A beneficiary is responsible for 20 percent of the Part B approved charges for covered services (after the deductible).
    C. A beneficiary must also pay the difference between the actual charge and the Medicare approved charge, up to a specified limit (15%), when the physician or supplier does not accept Part B assignment. These are called excess charges.

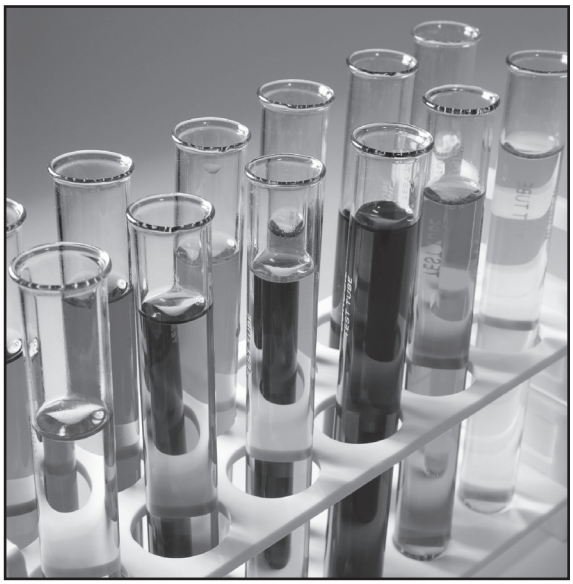
Physician services

Part B helps pay for covered services received from a doctor in his or her office, in a hospital, in a skilled nursing facility (SNF), in the home or any other location in the United States or its territories.

1. For Medicare purposes, the term doctor includes licensed:
    A. Physicians (i.e., doctors of medicine (M.D.) or osteopaths (D.O.))
    B. Dental surgeons.*
    C. Chiropractors.*
    D. Optometrists.*
    E. Podiatrists.*
    F. The term doctor does not include Christian Science practitioners or naturopaths.
    G. Other qualified reimbursable health care professionals include clinical psychologist and social worker, physician assistant, certified nurse-midwife, nurse practitioner and dietician.

* Part B coverage for services by this provider is limited.

2. Part B covered services
    A. Medical and surgical services including anesthesia
    B. Diagnostic tests and procedures including X-rays
    C. Outpatient hospital services
    D. Drugs and biologicals administered by professionals
    E. Medical equipment and supplies other than common first-aid needs
    F. Visit to physician for second opinion about recommended surgery for treatment of a Medicare covered medical condition.
        1. Medicare beneficiaries are encouraged to seek a second opinion about recommended nonemergency surgery. If the first two opinions contradict each other, Medicare will help pay for a third opinion.
        2. Medicare pays for a second opinion the same way it pays for other doctor services (i.e., 80 percent of approved amount; you pay 20 percent coinsurance).



    G. Laboratory services (e.g., blood tests and urinalysis)
        1. The provider must accept assignment. Part B pays 100 percent of approved charges for covered clinical diagnostic tests (except in rural health clinic labs where deductibles and coinsurance apply).
        2. These payments do not count toward meeting the yearly deductible.
        3. Labs may be independent, hospital outpatient or in a doctor's office, and must be certified.
    H. Emergency room
    I. Smoking cessation
    J. Splints and casts
    K. Blood transfuctions furnished to an outpatient starting with the fourth pint

3. Limited covered services
    A. Chiropractic services: Part B pays for manual manipulation of the spine to correct a subluxation (dislocation). Part B does not pay for X-ray services provided by a chiropractor.
    B. Podiatry services: Part B does not cover routine foot care such as cutting or removal of corns or calluses, trimming nails, other hygiene and preventive maintenance care unless the beneficiary has a systemic disease which would make the unskilled performance of such procedures hazardous (i.e. diabetic).

Part B mental health services

Mental health services are subject to a payment limitation called outpatient mental health treatment limitation. This payment schedule is in the process of being changed to the standard Part B 80/20 split.
    A. These services are paid at 50 percent of approved charges after the Part B deductible is met.
    B. Outpatient treatment of mental illness can be provided by a physician, a clinical psychologist or a clinical social worker.
    C. Part B will pay for the treatment of a mental, psychoneurotic or personality disorder for an individual who is not an inpatient. NOTE: Evaluation for services such as psychiatric testing and evaluation to diagnose the patient's illness are not subject to the limitation.

Rehabilitation therapy

A. Doctor must prescribe service, set plan of treatment and review the plan on a regular basis.
B. The therapy services can be received in one of three ways:
1. Services can be received in a physician's office
2. Services can be received directly from an independently practicing Medicare-certified physical or occupational therapist in his/her office or in the home if such treatment is prescribed by a physician.
3. Services can be received as an outpatient of a hospital, SNF, home health agency, clinic, rehabilitation agency or public health agency approved by Medicare.

Part B ambulance

Part B covers ambulance service in approved vehicles when transportation in another vehicle would endanger the beneficiary's health.

1. Medicare will pay for transportation from home to the nearest hospital or skilled nursing facility or from the hospital or skilled nursing facility to home. This coverage is limited to specific situations:
- The service is considered reasonable and necessary, OR
- Other means of transportation cannot be used due to medical conditions.

A. Emergency ambulance transportation to the nearest facility will be considered by Medicare when the patient:
- Suffers from severe pain, bleeding or shock
- Is unconscious
- Must be restrained to prevent injury to self or another person
- Has suffered an accident, injury, stroke or heart attack
- Must remain immobile because of a bone fracture
- Requires oxygen or other medical treatment during transport.

B. Medicare covers ambulance transportation in nonemergencies and when the patient is bed confined. Medicare considers one to be bed confined if the patient is:
- Unable to get out of bed without assistance.
- Unable to walk.
- Unable to sit in a chair or wheelchair.

2. Medicare will not pay for ambulance use as routine transportation.

3. Air ambulance may be covered if:
A. The medical condition endangers the life or seriously imperils the health.
B. Immediate medical treatment is required for survival or to avoid severe health damage.
C. Land transportation is not available or would endanger life or health.

NOTES: For Medicare to pay, a doctor or other medical professional must certify that a non-emergency ambulance transport is medically necessary. Certification can occur either before or after transport.

Medicare occasionally denies air ambulance claims—always appeal. Ambulance claims are generally processed where the patient originated.

Part B durable medical equipment

Part B covers durable medical equipment (DME) and supplies under two general conditions:

A. A physician must order or prescribe the equipment prior to purchase or rental of the equipment
B. The equipment must be medically necessary.

Most DME claims are processed by:

Noridian DMERC
Medicare
901 40th Street South, Suite 1
Fargo, ND 58103-2146
1-800-633-4227
www.noridianmedicare.com

1. Durable medical equipment must be for use in the patient's home, be able to withstand repeated use, and primarily serve a medical purpose. It includes:

A. Oxygen equipment
B. Wheelchairs
C. Certain other medically necessary equipment

2. Covered supplies/equipment include:

A. Prosthetic devices, which are devices needed to substitute for an internal organ (i.e., heart pacemakers), corrective lenses needed after cataract surgery, and colostomy and ileostomy bags and certain related ostomy supplies.
B. Artificial limbs and eyes; and arm, leg, back and neck braces.
C. Supplies ordered by a physician in connection with medical treatment immediately after surgery for a specified time, e.g., surgical dressings. Splints and casts are processed by the local Medicare contractor.
D. Re-agent (test) strips, lancets and other supplies necessary for the proper functioning of a blood glucose monitor (diabetics). The amount of lancets and test strips covered every month depends on whether or not you use insulin to control diabetes.
    - Medicare will also pay for a glucose monitor machine (for insulin and non-insulin dependent diabetics).
    - Medicare covers one pair per year of therapeutic shoes and shoe inserts for people with severe diabetic foot disease.
    - Self-management training is also covered for diabetics under certain circumstances.

NOTE: Non-insulin dependent beneficiaries should have their physician submit a letter stating when they received the glucose monitor. Otherwise, the carrier will deny claims for the test strips.

3. Noncovered durable medical equipment items include:

A. Exercise equipment
B. Bathtub rails, shower chairs, hi risers
C. Hearing aids, dentures
D. Adult diapers or underpads (may be covered with certain diagnoses such as cerebral palsy)
E. Support hose, elastic stockings

F. Telephone alert/communication aids
G. Most prescription drugs
H. Routine first aid supplies

4. Documentation for DME supplies may include:
    A. Written order
    B. Written order prior to delivery
    C. Certificate of Medical Necessity required for some items.
        1. CMS form with four sections. Sections B and D should be completed by physician or staff; Sections A and C should be completed by supplier.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARE SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 02.03A

MOTORIZED WHEELCHAIRS

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(_ _ _) _ _ _ - _ _ _ _ HICN _____	(_ _ _) _ _ _ - _ _ _ _ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODES: _____ _____ _____ _____
PT DOB ___/___/___; Sex ___ (M/F); HT. ___ (in.); WT. ___ (lbs.) PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (_ _ _) _ _ _ - _ _ _ _ UPIN # _____	

SECTION B **Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** | **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
Motorized Whlchr Base and All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Height Armrest	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1–24) (Round up to the next hour)
Motorized Whlchr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whlchr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See instructions on back.)* If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on Form CMS-854.

☐ **CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON Form CMS-854**

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

CMS-843 (0597)

4/2005

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories,supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY

DMERC 484.2

OXYGEN

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION __/___/__

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(_ _ _) _ _ _ - _ _ _ _ HICN _____		(_ _ _) _ _ _ - _ _ _ _ NSC # _____
PLACE OF SERVICE _____	HCPCS CODE	PT DOB ___/___/___; Sex ___ (M/F); HT.____(in.); WT.____(lbs.)
NAME and ADDRESS of FACILITY if applicable (See Reverse)	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (_ _ _) _ _ _ - _ _ _ _ UPIN # _____

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ANSWERS	ANSWER QUESTIONS 1-10. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
a) _____ mm Hg b) _____% c) ___/___/___	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO_2 and/or (b) oxygen saturation test. Enter date of test (c).
Y N	2. Was the test in Question 1 performed **EITHER** with the patient in a chronic stable state as an outpatient **OR** within two days prior to discharge from an inpatient facility to home?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7). Print/type name and address below: NAME: ADDRESS:
Y N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.
_____ LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X".
a) _____ mm Hg b) _____% c) ___/___/___	7. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO_2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
IF PO_2 = 56–59 OR OXYGEN SATURATION = 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.	
Y N D	8. Does the patient have dependent edema due to congestive heart failure?
Y N D	9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N D	10. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.
PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

FORM CMS-484 (11/99)

4/2005

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories,supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

Home health

The Balanced Budget Act (BBA) of 1997 transferred from Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or SNF.

1. Beginning Jan. 1, 1998, Part A will cover only postinstitutional home health services for up to 100 visits during a home health spell of illness:
    A. Except for those persons with Part A coverage only, who will be covered for services without regard to the postinstitutional limitation.

2. Part B covers home health services not associated with a hospital or nursing home stay or if you exhaust the 100 visits under Part A.

Other prevention Part B services

1. "Welcome to Medicare" physical exam
    A. Available only within the first six months of enrolling in Part B
    B. One-time only
    C. You pay 20 percent of the Medicare-approved amount after you meet the yearly Part B deductible.

2. Portable diagnostic X-ray services
    A. Part B covers these services when received at home if a physician orders them.
    B. Equipment must be provided by a Medicare certified supplier.

3. Mammography screenings
    A. Part B covers a yearly mammography screening for female Medicare beneficiaries over 40.
    B. The Part B deductible is waived.
    C. Twenty percent copayment must be paid by beneficiary.
    D. Under some circumstances, diagnostic or screening mammograms may be covered more frequently.

4. Pap smears and pelvic exams
    A. The Part B deductible is waived.
    B. Twenty percent copayment must be paid by beneficiary.
    C. Tests may be conducted every two years.
    D. Medicare will cover more frequent screenings if a physician considers a woman to be at high risk of developing cervical cancer.

5. Colorectal cancer screening
    A. All people with Medicare age 50 and older are covered.
    B. All tests are covered differently.
        • Fecal occult blood test—Once every 12 months.
        • Flexible sigmoidoscopy—Generally, once every 48 months
        • Screening colonoscopy—Once every 120 months (high risk every 24 months)
        • Barium enema—Once every 48 months (high risk every 24 months) when used instead of sigmoidoscopy or colonoscopy

    C. You pay nothing for the fecal occult blood test. You pay 20 percent of the Medicare-approved amount.

6. Bone mass measurements
    A. Medicare will cover bone mass measurement for certain high risk Medicare beneficiaries.
    B. Covered once every two years.

7. Vaccines
    A. Flu—covered yearly under Part B
    B. Pneumonia—normally only needed once in a lifetime. No cost.
    C. Hepatitis B—copays will apply

8. Medicare covers a yearly prostate cancer screening test for male Medicare beneficiaries over age 50. Coverage includes the screening digital rectal examination and prostate specific antigen blood test. Deductibles and copays apply.
9. Cardiovascular screening
    A. Tests cholesterol, lipid and triglyceride levels
    B. Available once every five years
    C. Deductibles and copayments are not required
10. Diabetes screening
    A. Available only for those at risk of developing diabetes
    B. Tests to be covered include a fasting plasma glucose test and post-glucose challenges
    C. Available up to twice a year
    D. Deductibles and copayments are not required
11. Smoking and tobacco use cessation counseling
    A. Available to people with Medicare who are diagnosed with a smoking-related illness or are taking medications that may be affected by tobacco
    B. Up to eight face-to-face visits may be covered in a 12-month period
    C. Beneficiary is responsible for 20 percent copay after Part B deductible
12. Glaucoma tests
    A. People with Medicare whose doctor says they are at high risk for glaucoma
    B. Once every 12 months
    C. You pay 20 percent of the Medicare-approved amount after the yearly Part B deductible.
13. Abdominal aortic aneurysm
14. Medical nutrition therapy

Services not covered by Part B

A. **Routine physical examinations** (except for Welcome to Medicare exam performed within six months of initial Medicare enrollment) and tests directly related to such examinations
B. **Routine foot care**
    1. Medicare will cover treatment of injuries or diseases of the foot such as hammer toe, bunion deformities and heel spurs.
C. **Eye or hearing examinations**, specifically for prescribing or fitting hearing aids or eyeglasses. Medicare does cover the first set of lenses after cataract surgery.
D. **Routine immunizations** except flu, pneumonia and hepatitis B
E. **Cosmetic surgery** unless needed because of accidental injury or to improve the functioning of a malformed part of the body.
F. **Dental care** except for surgery of the jaw or related structures or setting fractures of the jaw or facial bones. Pulling teeth to prepare for radiation may be covered.

G. **Acupuncture**
H. **Self-administered drugs** except some immunosuppressive drugs and oral cancer drugs. Generally, all self-administered medications are covered under Part D unless a beneficiary would be inpatient. Then they would be covered under Part A.

Participating physician/supplier program

Each year, CMS invites providers to enter Participating Physician/ Supplier Agreements. Providers who sign these agreements accept assignment on all claims for Medicare patients for that year. Providers can sign up as participating providers in December for the following year. Carriers publish a Medicare Participating Provider/ Supplier (MEDPARD) directory listing all participating providers in the area.

To access the MEDPARD directory go to www.noridianmedicare.com.

Assigned claims/unassigned claims/private contracting

Three payment options

The approved charge is the amount set by the Medicare fee schedule for covered services and supplies and upon which Part B payment is based.

A. The **assigned claim** (a.k.a. accepting assignment). Definition: **A physician or supplier accepts assignment for a claim when he or she accepts Medicare's approved charge as full payment. Medicare generally pays 80 percent of the approved charge and the beneficiary is responsible for 20 percent**. Providers must accept assignment for anyone on Medical Assistance (Medicaid).

Example of assigned claim for Part B services:

Mr. Anderson's bill for surgery totaled	$1,500
Medicare Part B approved	$1,000

The surgeon accepted assignment, so Mr. Anderson is not responsible for paying any excess charges. If Mr. Anderson has met his deductible:

- Medicare pays 80 percent of the approved charge ($1,000 x 80%) $ 800
- Mr. Anderson pays the 20 percent coinsurance ($1,000 x 20%) $ 200

TOTAL= $1,000

(Medicare approved amount because the facility accepted assignment)

1. Providers choose whether or not to accept assignment. A nonparticipating provider may accept assignment on a case-by-case basis. In most cases, the beneficiary must ask the provider about accepting assignment.

2. The following Medicare health care practitioners must accept assignment:
   - Ambulance companies
   - Claims for drugs/biologicals
   - Certified registered nurse anesthetist
   - Clinical nurse specialist
   - Clinical psychologist
   - Clinical social worker
   - Dieticians/nutritionists
   - Physician assistant
   - Nurse practitioner
   - Nurse midwife

3. Claims process for assigned claims
    A. The provider must file the claim with Medicare.
    B. The carrier sends a Medicare Summary Notice (MSN is sent every three months) to the beneficiary detailing the charges from the assigned claim.
    C. The carrier pays the provider directly (i.e., sends a check to the provider for 80 percent of the approved charge). Beneficiary handles no checks from Medicare under an assigned claim.

B. **The unassigned claim** (a.k.a. not accepting assignment). Definition: If a physician or supplier does not agree to accept Medicare's approved charge as the total charge, it is called an unassigned claim.

1. The beneficiary may be responsible for a portion of the excess charge over the approved charge (in addition to the 20 percent coinsurance payment). The current limit on charges is 15 percent of the Medicare approved charge.
2. The physician or supplier may ask the patient to pay at time of service.

Example of unassigned claim for Part B services:

Mr. Anderson's bill for surgery totaled	$1,500
Part B approved	$1,000

The surgeon did not accept assignment, so Mr. Anderson is responsible for paying the excess up to 115 percent of the approved amount.

If Mr. Anderson has met his deductible:

• Medicare pays 80 percent of the approved charge	($1,000 x 80%) $ 800
• Mr. Anderson pays the 20 percent coinsurance	($1,000 x 20%) $ 200
• Plus he pays the excess up to 115 percent of the approved charge	($1,000 x 115%) $ 150

NOTE: Approved charges usually are less than actual charges.

3. Claims process for unassigned claims
    • The provider must file the claim with Medicare.
    • Carrier sends a Medicare Summary Notice (MSN) to the beneficiary detailing the various charges.
    • Attached to the MSN is a check to the beneficiary for 80 percent of the approved charge.
    • The beneficiary should cash the check or endorse it to the provider. The beneficiary must pay the provider the amount due directly (the Medicare amount, the coinsurance and the excess charge, if any).
    • MSNs have included a line item listing the 15 percent limiting charge or excess charge.
    • A nonparticipating provider must give the beneficiary an estimate before elective surgery over $500.
    • If the physician does not provide this information in writing before the procedure, he/she cannot charge for any amount above the Medicare approved charge.

C. **Private contracting**: Section 4507 of the Balanced Budget Act of 1997 allows doctors to enter into a third option of health care with Medicare beneficiaries. Doctors can enter into private contracts to provide Medicare-covered services to Medicare beneficiaries.

A. This third option keeps the assumption that Medicare law has always allowed beneficiaries to go to the doctor of their choice.
B. Doctors can opt out of Medicare and enter into private contracts with beneficiaries to provide Medicare covered services at a rate set by the doctor.

C. In exchange for being able to set their own rate schedules, doctors must agree to give up Medicare payment for ALL patients for two years after entering into the private fee arrangement. Doctors must also inform beneficiaries that they WILL NOT be reimbursed by Medicare or a Medicare supplemental policy for the servicse they will receive, even though the services would be covered under Medicare.

D. Beneficiaries will know when they enter into a private contract and before they receive the health services that they will be personally responsible for the FULL amount of the bill.

E. With this private contracting option, doctors will not be able to pick and choose which beneficiaries to treat based on financial or health status.

CLAIM INFORMATION SHEET

Name _____

Year _____

MEDICARE PRIVATE INSURANCE

HIC #_____ COMPANY_____ POLICY #_____

Date of Service	Provider	Unassigned & Assigned	Amount Billed	Maximum Limit	Amount Approved	Amount Paid	Balance Due	Date Submitted	Amount Paid	Date Paid	Amount Not Covered

Medicare Part B medical insurance exercise

1. What type of medical services does Medicare Part B cover?

A. C.

B. D.

2. What is the monthly premium for Medicare Part B?

3. Medicare Part B coverage for eligible beneficiaries is optional. T _____ F _____

4. The Part B calendar year deductible is:

5. Medicare pays 80 percent of approved charges on most covered Part B services. T _____ F _____

6. Explain Medicare's approved charges.

9. Medicare will pay for X-rays furnished by a chiropractor. T _____ F _____

10. Dental care services covered by Medicare are very limited. T _____ F _____

11. Medicare Part B will pay for prescription drugs purchased at the local pharmacy. T _____ F _____

12. Medicare pays 80 percent of the approved charges for treatment of outpatient mental illness. T _____ F _____

13. What are two conditions that must be met for Part B to cover durable medical equipment and supplies?

A.
B.

14. What are some of the preventive health care services covered by Medicare?

15. When providers accept assignment, they accept Medicare's payment of 80 percent plus the beneficiaries' 20 percent of the approved charge as payment in full for the service. T _____ F _____

16. A nonparticipating physician may accept assignment on a case-by-case basis. T _____ F _____

17. Who is responsible for the portion of a physician's bill that is not paid by Medicare?

18. Physicians or practitioners can have private contracts with some Medicare beneficiaries but not others. T _____ F _____

19. The three payment options available to physicians as of January 1, 1998, are accepting assignment, not accepting assignment, and _____.

Word match

_____ Deductible	1. A providers claim who do not accept Medicare's approved amount (can charge 15% more than Medicare's rate)
_____ DME	2. A detailed list of charges received from a Medicare assigned claim
_____ Assigned claim	3. Durable medical equipment such as walkers, wheelchairs and oxygen
_____ Unassigned claim	4. A providers acceptance of Medicare's approved reimbursement (80/20)
_____ Private contracting	5. Flat dollar rate a beneficiary must pay before they are eligible for benefits
_____ MSN	6. A third option providers have for payments from beneficiaries; providers cannot accept Medicare payments for a timeframe if they enter into this contract.